



**Northern Arizona Healthcare**

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Betty Gould  
Regulations Officer  
Division of Regulatory Affairs  
Records Access and Policy Liason  
Indian Health Service  
801 Thompson Avenue, Suite 450  
Rockville, MD 20852

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RE: Proposed Rule  
SECTION 506 MEDICARE MODERNIZATION ACT  
Limitation on Charges for Services Furnished by Medicare Participating Inpatient  
Hospitals to Indians

Dear Ms. Gould:

Thank you for the opportunity to respond to the April 28, 2006 Proposed Rule regarding Limitation on Charges for Services Furnished by Medicare Participating Inpatient Hospital to Indians.

First, in reviewing the rule, we have noted that the proposal to accept payment at Medicare-like rates is unilateral. Our concern is for the amount of time that it has historically taken for the Service Units to pay their claims, if they pay the claims at all. It is not uncommon for the Service Units to take six or nine months to adjudicate and pay a clean claim. If the Indian Health Service desires to pay Medicare-like rates, then it should be required to do so in Medicare-like time frames.

Second, payment for services should be absolute, for services rendered, not at the service units' discretion. Timelines for notification of Emergency Services to the Indian Health Service or Tribe should be set at a minimum of 30 days following services rendered. There are many occasions when it is unclear whether the patient is covered under a state Medicaid plan, which occurs more than 95% of the time, or whether the patient is covered through Indian Health Service.

Third, the Public Health Service Hospitals in our area are not able to provide 24 hour, 7 day a week, coverage in numerous specialty clinical areas. As a result, any emergent patient that comes in outside of these hours is shifted to our facility, rather than the public health service hospital taking care of its own patients, at its own cost. As a result, the cost of care for these patients is substantially dissimilar to the patient population as a whole since it occurs primarily on nights, weekends and holidays, when the Public Health Service Physicians, refuse to take call or take care of their patient population locally. Medicare-like rates do not pay for the costs that we incur to maintain availability of services 24 hours a day, 7 days a week, where the government won't in their facilities.

Fourth, the payment at Medicare-like rates should be set at a premium to base Medicare rates, rather than at an amount equal to Medicare rates. The Native American population has many complications and co-morbidities that do not exist in the patient population as a whole. Hospitals receive additional reimbursement through Medicare Disproportionate share payments which is based in part on Medicare SSI days, but is only applicable for true Medicare SSI patients, not Medicare-like patients paid for by the Indian Health Service. As a result, the Indian Health Service would be paying less for its patient population, than Medicare actually pays on a comparable population.

For instance, in Arizona, the following SSI ratios exist amongst Public Health Service Hospitals, with an average of 34.78% of all Medicare days being SSI, indicating a high degree of complicating pre-existing factors and medical conditions amongst the Native American population. The table below contains the most recent Medicare SSI published data:

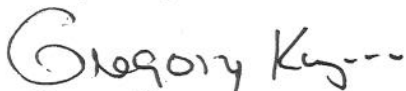
Provider #	Provider	SSI Days	Medicare Days	Ratio
030071	FORT DEFIANCE INDIAN HOSPITAL	607	1760	34.49%
030073	TUBA CITY REGIONAL HEALTH CARE CORP	1607	3774	42.58%
030074	SELLS INDIAN HEALTH SERVICE HOSPITA	108	406	26.60%
030077	PHS INDIAN HOSPITAL-SAN CARLOS	23	85	27.06%
030078	PHOENIX INDIAN MEDICAL CENTER	356	2280	15.61%
030084	CHINLE COMPREHENSIVE CARE FACILITY	951	2195	43.33%
		3652	10500	34.78%

These ratios compare to an overall SSI ratio in the State of Arizona of 6.74%, for all Medicare Patients. So the Indian population, as a whole in the state, has an SSI incident rate of 5.2 times the statewide average. Clearly this would indicate that the Native American population has much different needs than the Medicare population as a whole and would utilize services in a much different and distinct pattern. Thus for the Indian Health Service to pay Medicare-like rates, on a non Medicare-like population is egregious.

Accordingly, we would propose that the Indian Health Service conduct an actuarial study to ascertain that the members they cover have conditions no more chronic or acute the general Medicare population if it proposes to pay at Medicare rates.

Should you have any questions or need additional information, please do not hesitate to contact me at (928) 773-2006. Your assistance will be appreciated.

Respectfully,



Gregory Kuzma  
Vice-President / Chief Financial Officer